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PLAINTIFF'S EXHIBIT 5

January 13, 2005

RE: HOUSTON, Samuel
DOB: 02/28/19554

To whom it may concern,

I am writing this letter to outline my assessment and treatment of low back pain and lower extremity pain that my patient, Mr. Samuel Houston, has experienced.

I initially saw Mr. Houston on October 13, 2004 when he presented with severe left low back pain, left buttock pain, left posterior thigh pain, and distal left lower extremity pain and paresthesias. Prior to this, Mr. Houston had a past medical history that was significant for a very long history of low back pain and right leg pain, dating back to approximately 1977 with the patient having had a 22-year history of back pain and right leg pain.

While the patient was still on active duty in the Air Force, he finally underwent surgery for his low back at Kessler Air Force Base around January of 2000. At that time, the patient, by report, underwent an L4-5 discectomy for right-sided sciatica and a foot-drop.

The patient did have improvement in his low back pain and right lower extremity symptoms following that operation.

The patient then had the more recent new onset of left low back pain and left lower pain, paresthesias and weakness in August of 2004. An MRI of the lumbosacral spine from September 7, 2004 showed disc bulge/protrusions and disc/osteophyte complexes from L2-3 down through L5-S1. At L4-5, there was a broad-based disc bulge/protrusion with posteromarginal osteophytes and facet hypertrophy, resulting in significant spinal stenosis and significant lateral recess stenosis. The patient also had scar tissue and adhesions from previous surgery at L4-5.

Mr. Houston underwent microscopic decompressive laminectomies, medial facetectomies, and foraminotomies at L3, L4, L5 and S1 to decompress the nerve roots and thecal sac, along with a re-do left L4-5 microdiscectomy to decompress the left L4 and L5 nerve roots with neurolysis of scar tissue and adhesions from previous spinal surgery on November 10, 2004.

He has had improvement in his left lower extremity since this most recent surgery.

Mr. Houston still continues to have muscle spasms and aching in his lower back, particularly when he has been up on his feet for any significant period of time. Mr. Houston has been on a

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long course of narcotic analgesics including fentanyl patches and he is on a tapering dose of these narcotic fentanyl patches.

Mr. Houston also gets intermittent paresthesias radiating into his right upper extremity involving the second, third, fourth and fifth digits and also some intermittent shock-like sensations radiating from his neck down into his spine.

I would recommend Mr. Houston not return to doing heavy mechanical aircraft work as he has had two disc herniations at L4-5 requiring surgery and he would be at increased risk for recurrent disc herniations if he were to perform strenuous, heavy physical activities that might strain or injure the lower back.

Furthermore, Mr. Houston does have MRI evidence of disc/osteophyte complexes from L2-3 down through L5-S1, and additional stresses and strains on the lower back might cause progression and disease of some of those disc levels, as well.

I would recommend Mr. Houston be retrained for a position that would allow him a more sedentary job so as to avoid any additional stresses and strains that might re-injure his lower back or cause further injury to other degenerated disc levels.

I appreciate your kind consideration of my patient.

Sincerely,

Thomas J. Manski, M.D.

TJM/mlw